

Accepted 6/1/09 Alliance

PRINTED: 04/16/2009
FORM APPROVED

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN105AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <i>Rec'd 4-20-09</i> 04/09/2009
NAME OF PROVIDER OR SUPPLIER CARSON VALLEY RESID CARE CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 1189 KIMMERLING RD GARDNERVILLE, NV 89410		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 4/7/09 and 4/9/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 84 Residential Facility for Group beds for elderly and disabled persons, Category II residents. The census at the time of the survey was 70. Sixteen resident files were reviewed and fifteen employee files were reviewed. One discharged resident file was reviewed. The facility received a grade of A. The following deficiencies were identified:	Y 000		
Y 255 SS=F	449.217(6)(a)(b) Permits - Comply with NAC 446 NAC 449.217 6. A residential facility with more than 10 residents must: (a) Comply with the standards prescribed in chapter 446 of NAC. (b) Obtain the necessary permits from the Bureau of Health Protection Services of the Division.	Y 255		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Karen L. Perry
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE *ADMINISTRATOR*

(X6) DATE
4-27-09

STATE FORM

6899

JRRT11

If continuation sheet 1 of 3

RECEIVED

APR 27 2009

BUREAU OF LICENSURE
AND CERTIFICATION
CARSON CITY, NEVADA

Bureau of Health Care Quality & Compliance

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Y 255	Continued From page 1 This Regulation is not met as evidenced by: Based on observation, record review, and interview on 4/9/09, the facility failed to ensure its kitchen complied with State standards for the storage, preparation and distribution of food. Findings include: - The toaster and hand mixer did not meet the NSF certified standards. Domestic dining room refrigerators designated for the resident's personal snack use were not marked as such. - Thawed sliced meats were mis-dated and sliced melon and other fruit in the walk-in refrigerator were not dated. - The juncture between the dish-sink, the wall and the refrigerator handle needs to be repaired so that they can be easily cleaned. - The mixture used in the spray-bottles for cleaning surfaces did not consistently measure 100-200 parts per million in strength of chlorine. - The bottom of the back door to the kitchen did not seal to prevent the entry of pests. Severity: 2 Scope: 3 Y 878 SS=D 449.2742(6)(a)(1) Medication / Change order NAC 449.2742 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in	Y 255	<p>Y 255 ✓ TOASTER + mixer have been removed 4/9/09 from kitchen, sign has been posted on refrigerator designated for resident's use only.</p> <p>✓ DIETARY COOK'S HAVE BEEN GIVEN AN IN-SERVICE TO RE-DATE ANY FROZEN ITEMS REMOVED FOR DEFROST. (SEE ATTACHMENT "A")</p> <p>✓ ALL REPAIRS HAVE BEEN REPAIRED. (SEE ATTACHMENT "B")</p> <p>✓ PURITAN SERVICE SOLUTIONS REP. INSPECTED CHLORINE STRENGTH + DILUTION. (SEE ATTACHMENT "C")</p> <p>✓ SEAL HAS BEEN ATTACHED TO KITCHEN DOOR TO PREVENT PEST ENTRY (SEE ATTACHMENT "D")</p>		

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Y 878	Continued From page 2 the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order. This Regulation is not met as evidenced by: Based on record review and interview on 4/7/09, the facility failed to ensure 2 of 16 residents received medications as prescribed (Resident #1 and #4). Severity: 2 Scope: 1	Y 878	Resource Pharmacy will Receive copy of "OTC" Label with copy of RX ORDER from physician when delivery is incorrect. Due to multiple ERROR + COMMUNICATION Problems with Resource Pharmacy during PAST 3 mths we ARE TERMINATING SERVICE Agreement + Returning To Med CARE Pharmacy effective 5/1/09.	Approved Mf 4/29/09

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